APPENDIX

SCHEDULE OF EXHIBITS

Exhibit A—*Peterson v. Weinberger* (Dist. Ct. Tex., 1973) F.Supp. 1259, a copy of trial court's opinion in instant case A1

Exhibit B—*Peterson v. Weinberger* (CA5, 1975) 508 F.2d 45, a copy of the decision in instant case in the appellate court B1

Exhibit C—*U.S. v. Peterson* (CA5, 1974) 488 F.2d 645, prior decision of court of appeals on identical facts, absolving appellant C1

Exhibit D—Constitutional and statutory provisions—texts thereof D1

Exhibit E—Summary of Federal penal statutes applicable to a Medicare or Medicaid claim E1

Exhibit F—Order denying petition for rehearing F1

EXHIBIT A

Donald M. PETERSON, D.O., Plaintiff,

v.

Elliott L. RICHARDSON, Secretary of Health, Education and Welfare, et al., Defendants,

v.

James E. PETERSON, Third Party Defendants.

Civ. A. No. CA-3-5158

United States District Court, N. D. Texas, Dallas Division.

Oct. 29, 1973.

MEMORANDUM OPINION

ROBERT M. HILL, District Judge

Dr. Donald M. Peterson filed this action against the Department of Health, Education and Welfare (hereinafter "HEW") and certain government officials and insurance carriers who administer the Medicare Act. He seeks injunctive relief reinstating him as a participating physician under the medicare programs and the recovery of certain sums which have been withheld from him under the medicare programs. He also seeks compensatory and punitive damages against individual defendants for suspending his medicare payments. Defendant United States of America filed a counterclaim against Dr. Peterson and a third party complaint against his

brother, James E. Peterson, alleging that they made and presented, or caused to be made and presented, false, fictitious and fraudulent claims for payment of medical treatment and services rendered to medicare beneficiaries. This counterclaim and the third party complaint were brought pursuant to the False Claims Act, 31 U.S.C. § 231.[1]

Dr. Peterson's Suspension

Dr. Peterson is a licensed physician of osteopathy practicing in the City of Dallas. A large portion of his practice is devoted to the care and treatment of patients eligible to receive medicare benefits. In June of 1969 a complaint relating to Dr. Peterson was received by the Bureau of Health Insurance (hereinafter "BHI"), a department of HEW. Defendants James A. Adams (hereinafter "Adams"), Donald Paul Chancellor (hereinafter "Chancellor") and Carl Gruninger (hereinafter "Gruninger"), employees of HEW, then commenced an investigation of certain claims for medicare payments submitted in April of 1969 for services rendered by Dr. Peterson in the spring of 1968. During this investigation defendant Martha A. McSteen (hereinafter "McSteen") was the regional represen-

[1] Relevant portions of this Act are:

"Any person . . . who shall make or cause to be made, or present or cause to be presented, for payment or approval . . . any claim upon or against the Government of the United States . . . knowing such claim to be false, fictitious or fraudulent, or who, for the purpose of obtaining or aiding to obtain the payment or approval of such claim, makes, uses, or causes to be made or used, any false bill, receipt, voucher, roll, account, claim, certificate, affidavit, or deposition, knowing the same to contain any fraudulent or fictitious statement or entry . . . shall forfeit and pay to the United States the sum of $2,000, and in addition, double the amount of damages which the United States may have sustained by reason of the doing, or committing such act . . ."

tative of the BHI and in that capacity she supervised the investigation.

In December of 1969 it was determined from this investigation that 123 fraudulent claims had been presented to defendants Blue Cross-Blue Shield of Texas (hereinafter "Blue Cross-Blue Shield"), Group Hospital Service, Inc. (hereinafter "Group Hospital"), and Group Medical and Surgical Service (hereinafter "Group Medical"), all of whom are insurance carriers and fiscal intermediaries disbursing medicare and medicaid funds solely at the direction of BHI. This determination was based on HEW's finding that the medical treatment described in the claims was not rendered or personally directed by Dr. Peterson. As a result of this determination, Gruninger made the decision to suspend all medicare and medicaid payments to Dr. Peterson This action was taken pursuant to BHI regulations and also in accordance with the General Accounting Office Policy and Procedures Manual for Guidance of Federal Agencies.

Further investigation continued until October 6, 1971, when the matter was referred to the United States Attorney for criminal prosecution. On September 8, 1972, an indictment was returned by the grand jury charging Dr. Peterson and James E. Peterson with submitting false claims under the medicare program. Following a trial, James E. Peterson was found guilty on thirty-nine counts of submitting false claims and Dr. Peterson was found guilty on one count of conspiracy to defraud the United States. These convictions are now on appeal.

On October 28, 1971, this court issued a preliminary injunction directing HEW to rescind the suspension of Dr. Peterson as a participating physician in the medicare and medicaid programs and to direct its intermediaries to process and to pay all claims submitted by Dr. Peterson for his services under these programs.

I. *Dr. Peterson's Complaint*

Dr. Peterson urges three causes of actions. First, he seeks a money judgment for breach of contract since the defendants withheld some $90,000 for services which he had rendered under the medicare program. He claims that this was a malicious breach of contract, which under Texas law entitles him to tort damages and punitive damages. Second he alleges some seven different torts, all of which involve alleged maliciousness on the part of the individual defendants in suspending him from the medicare program and in withholding payments for services actually rendered under the medicare program.[2] Finally, he seeks a permanent injunction directing HEW to reinstate him as a participating physician under the medicare and medicaid programs and to refrain from ever again suspending him unless in compliance with the laws of the United States. This court is of the opinion that none of Dr. Peterson's causes of action are meritorious.

[2] The seven alleged torts are as follows: (1) invasion of, or interference with, property rights; (2) taking of property without due process of law; (3) maliciously inducing Blue Cross-Blue Shield and Travelers Insurance Company to breach their contract with Dr. Peterson; (4) extortion by "cruel devices" with deliberate intent to create total anguish and physical injury; (5) malicious conspiracy to punish without due cause; (6) malicious breaches of contract by Blue Cross-Blue Shield of Texas and Travelers Insurance Company; (7) interference with contract rights.

A. *Breach of Contract and Tort Causes of Action*

[1] This court is of the opinion that Dr. Peterson's first and second causes of action are without legal merit. Defendants McSteen, Adams, Gruninger and Chancellor are clearly immune from any liability under the doctrine of official immunity announced in *Barr v. Matteo*, 360 U.S. 564, 79 S.Ct. 1335, 3 L.Ed.2d 1434 (1959). In *Barr*, the Court held that the Acting Director of the Office of Rent Stabilization was immune from the libel laws of the District of Columbia for statements made within the scope of his employment, notwithstanding the fact that he acted with a malicious motive. The Court reasoned that it is "better to leave unredressed the wrongs done by dishonest officers than to subject those who try to do their duty to the constant dread of retaliation." 360 U.S. at 571-572, 79 S.Ct. at 1340. There has been no showing that the actions of defendants McSteen, Adams, Gruninger and Chancellor were outside the scope of the statutes, regulations and instructions in force at the time. The trial testimony indicates that these defendants were acting within the scope of their employment and pursuant to the directions of HEW to discover fraud in the submission of claims under the Medicare Act. No liability can be imposed on these individual defendants pursuant to Dr. Peterson's cause of actions since these defendants have acted solely in their official capacities.

[2] The defendants Blue Cross-Blue Shield, Group Hospital and Group Medical are also immune from any liability pursuant to Dr. Peterson's first and second causes of action. These defendants are insurance carriers who administer the

medicare and medicaid programs at the direction of HEW pursuant to the provisions of 42 U.S.C. §§ 1395h and 1395u. Regulations established pursuant to these statutes provide that:

> "In the performance of their contractual undertakings, the carriers act on behalf of the Secretary, carrying on for him the administrative responsibilities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program . . ." 20 C.F.R. § 405.670 (1973).

It is clear from these provisions and regulations that these carriers are agents of the United States. Since the evidence shows that they were acting within the scope of their agency relationship with HEW and in accordance with the applicable statutes, regulations and directive of HEW, any liability would be that of the United States. Johnson v. Johnson, 332 F.Supp. 510 (E.D.Pa.1971); Kuenstler v. Occidental Life Insurance Co., 292 F.Supp. 532 (C.D.Cal.1968).

[3-5] This court cannot find any basis in this case to impose tort liability on the United States for the conduct of its employees and the actions of HEW agents in suspending Dr. Peterson as a participating physician and in withholding the processing of all other payments to him when the fraudulent claims were discovered. This conduct was neither malicious nor unreasonable. HEW had the right to withhold Dr. Peterson's medicare payments under 31 U.S.C. § 227 as an offset for any final judgment rendered against him under the False Claims Act. In view of the determination, *infra*, that Dr. Peterson

did cause to be made a false claim, this court can find no tortious conduct on behalf of the United States, its employees and its agents. The court is also of the opinion that any liability for breach of contract was vitiated by the fraudulent conduct of Dr. Peterson as determined *infra*. Additionally, Dr. Peterson's claims against the United States for interference with contract rights and malicious prosecution are clearly barred by the terms of the Federal Tort Claims Act, 28 U.S.C. § 2680(h).

B. *Cause of Action for Injunctive Relief*

[6] Dr. Peterson alleges that he was denied procedural due process when HEW withheld his medicare payments and suspended him as a participating physician during the investigation of the fraudulent claims. This allegation is without merit. As the Supreme Court stated in Hannah v. Larche, " 'Due process' is an elusive concept. Its exact boundaries are undefinable, and its content varies according to specific factual contexts." 363 U.S. 420, 442, 80 S.Ct. 1502, 1514, 4 L.Ed.2d 1307 (1960). This court is of the opinion that within the "factual contexts" of this case, Dr. Peterson was afforded procedural due process.

Dr. Peterson and his attorney met in defendant Gruninger's office on June 18, 1970, for about two hours. After he was given the *Miranda* warnings, Dr. Peterson was informed that his medicare payments were being withheld pending the investigation of possible fraudulent claims which had already been paid. He was also advised that there was no dispute as to the validity of the claims being withheld from payment, but that

they were being withheld as an offset against any potential liability to the government. 31 U.S.C. § 227. During this conference, Gruninger outlined the reasons why HEW had reached the conclusion that the medicare claims in question were fraudulent and he cited specific instances. The conference was terminated with an agreement that HEW would write a letter outlining the allegations of fraud and that Dr. Peterson would then write a reply letter of explanation. Following the exchange of these letters, HEW rejected Dr. Peterson's contention that the medicare services covered by the disputed claims were rendered under his personal direction and thus were not fraudulent.

The decision to suspend Dr. Peterson and to withhold his medicare payments was in response to the determination by HEW that he had not rendered or personally directed the treatment described in the 123 claims To require HEW to hold any additional hearings on the suspension of Dr. Peterson and the withholding of payments would necessitate a determination by HEW on the merits of the fraudulent medicare payments, a determination which was properly reserved for the courts in the subsequent criminal prosecution and civil litigation where the full "panoply" of judicial procedures were available to Dr. Peterson. Therefore, under these circumstances,[3] the proceedings afforded Dr. Peterson by HEW were consistent with the constitutional dictates of procedural due process.[4]

[3] [W]hen a general fact-finding investigation is being conducted, it is not necessary that the full panoply of judicial procedures be used." Hannah v. Larche, 363 U.S. 420, 80 S.Ct. 1502, 4 L.Ed.2d 1307 (1960).

[7] Additionally, any injury to Dr. Peterson was rectified when this court issued the preliminary injunction on October 28, 1971. As a result of this court's determinations, *infra*, this court is of the opinion that the preliminary injunction in favor of Dr. Peterson should be dissolved and that his request for permanent injunctive relief should be denied.

II. *The Counter Claim and Third-Party Complaint*

In response to the original complaint, the United States has asserted a counterclaim against Dr. Peterson and a third-party complaint against James E. Peterson pursuant to the False Claims Act, 31 U.S.C. § 231 et seq. It is alleged that they made and presented, or caused to be made and presented, false claims for payment of medical treatment and services purportedly rendered to medicare beneficiaries.

A. *James E. Peterson*

[8] James E. Peterson was the principal owner and director of Concord Manor Nursing Home (hereinafter "Concord"); He was also the president and owner of Zodiac Enterprises, Inc. (hereinafter "Zodiac"), a subsidiary of Concord, which provided the services of registered physical therapists and physical therapy aids for nursing homes. Until March 1, 1969, Concord was certified to be reimbursed under Part A of the Medicare Act for in-hospital expenses and services (including physical therapy) rendered by Concord on behalf of medicare

[4] Administrative procedures for resolving any dispute Dr. Peterson may have had with the *carriers* were available pursuant to the provisions of 20 C.F.R. 405.801. There is no evidence that Dr. Peterson or his attorney ever attempted to invoke these procedures for an administrative review.

beneficiaries. Payments for these expenses and services come exclusively from a federal trust fund. Concord was never eligible to receive payments for Part B expenses which relate to physician services. On March 1, 1969, Concord and James E. Peterson were notified by a medicare carrier that due to Concord's failure to file cost reports, payments for physical therapy treatment rendered under Part A would be suspended.

During the month of April 1969, Group Medical received 123 "Request for Payment-Medical Insurance Benefits" claims under Part B. These claims were for physical therapy actually rendered a year earlier by Zodiac to patients at Concord. All but eight of these claims bore a signature purporting to be that of Dr. Peterson certifying that the physical treatment was rendered personally by him or under his personal direction. Additionally, all 123 claims bore the "physician code" number assigned to Dr. Peterson. Representatives of Group Hospital testified that Dr. Peterson's purported signature certifying that treatment described in each claim had been rendered by him or under his personal direction was a material statement upon which they relied in approving the payment of the 123 claims. Consequently, Dr. Peterson received medicare checks for each claim, totaling $16,153.44. These checks were deposited by Dr. Peterson in his bank account. He then wrote and delivered a check to Zodiac covering the deposit. It is the contention of the government that these 123 claims were actually submitted by James E. Peterson and were false and fraudulent claims since Dr. Peterson did not personally render or personally direct the treatment described in the 123 claims.

It is undisputed that Dr. Peterson did not sign these claims. Lucille Morton, an employee of Zodiac and Concord, who was charged with the responsibility of preparing claims for medicare payments, testified that she signed Dr. Peterson's name and physician code number to the disputed claims at the direction of James E. Peterson. James E. Peterson testified that he never directed Lucille Morton to sign his brother's name on the claims, however, he could offer no reasonable explanation as to why Lucille Morton would submit these claims bearing Dr. Peterson's signature and physician code number.

It is clear from the evidence that only James E. Peterson could benefit from his brother's signature on these claims. Since Concord was suspended from receiving any payments under the medicare programs the only way it could be paid for the treatment rendered before suspension, would be to submit claims under Part B. Part B, unlike Part A, requires a certification that the treatment was rendered by or under the personal direction of a physician. James E. Peterson was well aware of this requirement as demonstrated by a chart he personally prepared and introduced into evidence showing that Part B was "billable by physicians only." Further, Dr. Peterson testified that when he received the medicare checks, James E. Peterson requested that the proceeds be sent to Zodiac since the treatment was rendered by Zodiac. This court thereby finds that James E. Peterson knew that the claims required a physician's certification and that James E. Peterson instructed Lucille Morton to sign Dr. Peterson's name to these claims. This court concludes that James E.

Peterson violated the False Claims Act by submitting the 123 claims.

[9] James E. Peterson urges that these claims were not false since the treatment was actually rendered under the "personal direction" of Dr. Peterson in his capacity as medical director of Zodiac. Dr. Peterson and James E. Peterson testified that Dr. Peterson was the medical director of Zodiac. However, Helen Maeker, the only registered physical therapist for Zodiac, testified that she did not know that Dr. Peterson was the medical director. She also testified that he never gave her any directions in regard to the administration of physical therapy, nor was he present when she rendered any physical therapy in connection with these claims She was never told to consult with Dr Peterson with regard to any problems that may be encountered in performing physical therapy. The only contacts she had with Dr. Peterson were through his patients at Concord.

Helen Mathis, the director of nursing at Concord, also testified that she did not know that Dr. Peterson was medical director, nor did she ever see him supervise the administration of physical therapy at Concord. Lucille Morton, secretary-bookkeeper for Zodiac, did not know that Dr. Peterson was the medical director of Zodiac, nor was he ever compensated as a medical director of Zodiac. Weighing the testimony of these witnesses, this court finds that Dr. Peterson was not the medical director of Zodiac. Assuming however, that he was the medical director of Zodiac, the court finds that Dr. Peterson neither directed nor supervised the administration

of the treatment described in the 123 claims submitted by James E. Peterson. Thus, these services were not services of a physician payable under Part B of the Medicare Act. This court finds that the 123 claims submitted by James E. Peterson were false and that he knew that they were false.

B. *Dr. Peterson*

[10, 11] In response to the 123 claims submitted by James E. Peterson and in reliance of the purported certification that the treatment was rendered by Dr. Peterson or under his personal direction, Group Medical issued checks totaling $16,153.44 to Dr. Peterson as payee. These checks were deposited by Dr. Peterson with the knowledge that he had rendered no services related to these checks. The proceeds of these checks were then delivered to Zodiac. This court concludes that the act of Dr. Peterson in endorsing these checks and depositing them for collection with the knowledge that he was not entitled to the proceeds of the checks constitutes the making of a false claim as to each check. 31 U.S.C. § 231. United States v. Branker, 395 F.2d 881 (2d Cir. 1968); United States v. Scolnick, 219 F.Supp. 408 (D.Mass.1963). Further, the acts of Dr. Peterson, in combination with those of James E. Peterson, aided James E. Peterson in obtaining the funds paid on these false claims. The conclusion is inescapable that Dr. Peterson knew he was aiding James E. Peterson in obtaining payments on these false claims. Thus, Dr. Peterson is liable to the government on each claim under the provisions of 31 U.S.C. § 231.

III. *Conclusion*

From the foregoing, this court concludes that Dr. Peterson

and James E. Peterson have violated the provisions of the False Claims Act and that the United States is entitled to recover from Dr. Peterson and James E. Peterson the sum of $16,153.44, plus damages pursuant to the provisions of 31 U.S.C. § 231. Additionally, Dr. Peterson is not entitled to injunctive relief, tort damages or breach of contract damages against the defendants in this case. Counsel for the government is directed to submit an order consistent with this opinion.

JUDGMENT

On June 18, 1973, this cause came on for trial before the court and having heard the evidence and the argument of counsel, the court is of the opinion that judgment should be entered in accordance with its Memorandum Opinion which was filed on September 5, 1973. In that Memorandum Opinion the court found that Plaintiff Donald M. Peterson was not entitled to injunctive relief, tort damages or breach of contract damages against any of the defendants. The court further found that third party defendant James E. Peterson knowingly submitted 120 false claims for Medicare payments to the United States of America in violation of the False Claims Act, 31 U.S.C. § 231, and that Donald M. Peterson knowingly cashed checks in payment of such false claims and thereby aided James E. Peterson in submitting the 120 false claims in violation of the False Claims Act.

[12] The language of the False Claims Act provides that "any person . . . [who shall commit any of the acts prohibited] . . . shall forfeit and pay . . . the sum of $2,000,

and, in addition, double . . . damages." This statute has been interpreted as permitting the imposition of a separate forfeiture for each separate violation of the statute. United States v. Hess, 317 U.S. 537, 63 S.Ct. 379, 87 L.Ed. 443 (1942); Faulk v. United States, 198 F.2d 169 (5th Cir. 1952); United States v. Ueber, 299 F.2d 310 (6th Cir. 1962). The purpose of the $2,000 forfeiture provision is to reasonably indemnify the government for all losses arising from the false claims. The forfeiture was meant by Congress to reflect a fair ratio to damages in order to make sure the government would be made completely whole. United States v. Hess, *supra;* Toeleman v. United States, 263 F.2d 697 (4th Cir. 1959); United States v. Beatrice Foods Co., 330 F.Supp. 577 (N.D. Utah 1971).

[13, 14] Having considered all the evidence in this case and the efforts which the government has made in prosecuting these false claims, this court is of the opinion that the assessment of a $2,000 forfeiture for 120 false claims would be unreasonable and not remotely related to both the actual losses and inexplicable damages incurred by the government. This court concludes that the assessment of a $2,000 forfeiture for 50 of the false claims plus double damages for all 120 of the false claims would reasonably indemnify and make the government whole for the false claims made by James E. Peterson and Donald M. Peterson. The court is further of the opinion that interest should not be allowed on the money judgment but should be calculated from the date of entry of this judgment, at a rate allowed by state law. United States v. Foster Wheeler Corp., 447 F.2d 100

(2d Cir. 1971); United States v. Globe Remodeling Co., 196 F.Supp. 652 (D.Vt. 1961).

It is therefore ordered that plaintiff Donald M. Peterson take nothing by his action against all defendants and that his complaint be in all things dismissed; and,

It is further ordered that the United States of America recover of and from Donald M. Peterson and James E. Peterson, jointly and severally, the sum of $31,606.72, representing double damages for the 120 false claims in question; and,

It is further ordered that the United States of America recover of and from Donald M. Peterson and James E. Peterson, jointly and severally, the sum of $100,000 representing a $2,000 forfeiture for 50 of the 120 false claims in question; and,

It is further ordered that interest shall be recoverable on all amounts awarded from the date of this judgment at the rate allowed by Texas law; and,

It is further ordered that the preliminary injunction heretofore issued in this cause is dissolved and of no further force and effect.

EXHIBIT B

Donald M. PETERSON, Plaintiff-Appellant,

v.

Caspar W. WEINBERGER, Secretary of Health, Education and Welfare, et al., Defendants-Third-Party Plaintiffs-Appellees,

v.

James E. PETERSON, Third-Party Defendant-Appellant.

No. 74—1067.

United States Court of Appeals,
Fifth Circuit.

Feb. 14, 1975.

Physician brought action for alleged wrongful withholding of funds due him under the Medicare Act. The government filed a counterclaim against the physician and a third-party complaint against operator of nursing home for submission of false medicare claims. The United States District Court for the Northern District of Texas, Robert M. Hill, Jr., 370 F.Supp. 1259, rendered judgment in favor of the government and appeals were taken. The Court of Appeals, Dyer, Circuit Judge, held that conduct of employees of Bureau of Health Insurance in suspending physician from medicare program after investigation revealed possible fraud in submission of medicare claims was not malicious, negligent or unreasonable; that withholding of funds due physician as offset against false claims under investigation did not deny due process; and that evidence sustained determination that physician and

operator were liable to the United States under False Claims Act.

Affirmed.

Appeals from the United States District Court for the Northern District of Texas.

Before DYER, SIMPSON and CLARK, Circuit Judges.

DYER, Circuit Judge:

James E. Peterson and his brother, Dr. Donald M. Peterson, appeal from a money judgment entered against them for submitting false claims against the Government. Dr. Peterson also appeals from the denial of his entitlement to injunctive relief and tort and breach of contract damages against the defendants. We affirm.

Although much of the complicated statutory and factual background of this and the cognate cases[1] has been treated in the district court's opinion,[2] and in this Court's opinion on the appeal of the criminal trial of the Peterson brothers,[3] a recount of the salient facts is helpful to focus upon the issues raised by the Petersons.

James Peterson was the president, director, and a 69 per cent stockholder of Concord Manor Nursing Home, an extended care facility. He was also the sole owner of Zodiac Enterprises, Inc., which contracted with Concord and other nursing homes to provide physical therapy services to their

---

1 Peterson v. Blue Cross and Peterson v. West, 5 Cir. 1975,— F.2d —, this day decided.

2 Peterson v. Richardson, N.D. Tex. 1973, 370 F.Supp. 1259.

3 United States v. Peterson, 5 Cir. 1974, 488 F.2d 645.

patients. In 1968, Concord was a certified provider of services under Part A of the Medicare program. Medicare payments were handled through a fiscal intermediary, Mutual of Omaha, to whom Concord submitted its bills for services rendered at the nursing home at a daily rate which included physical therapy. Zodiac could not submit bills for its physical therapy services directly to the Medicare intermediary because Zodiac and Concord were related corporations, *i. e.*, James Peterson was the sole owner of one and held the controlling interest in the other. Therefore, the only way Zodiac could be reimbursed by Medicare for its services was for Concord to include physical therapy in its bills to Omaha. Only the cost, without profit, of services rendered was reimbursable. Concord was required to file cost reports each year with Omaha so it could determine the appropriate allowable cost. Concord failed to file these reports for 1967, and after three notices and the reduction of allowable daily rates, payments were stopped on March 1, 1969, and it ceased being a provider on August 31, 1969.

Thus, early in 1969, James Peterson was faced with a dilemma regarding physical therapy services: Zodiac could not bill directly for therapy services it had furnished to Concord in the first six months of 1968, and payments to Concord under Part A had been stopped. Thereupon, Peterson directed his employee, Morton, to prepare Part B claim forms and "get them out as soon as possible so he could get the money back in." This necessitated the use of a form different from that used for Part A in that it required a

physician's personalized provider number and the physician's signature certifying that the service had been rendered by him personally or under his personal direction. Morton and another employee prepared 120 Part B claims, signed Dr. Peterson's name and provider number to them, and put James Peterson's Post Office box number on the forms rather than Dr. Peterson's address. Morton testified that "Mr. Peterson gave us the instructions on all of the forms."

The Part B claims for Medicare payments were then sent to Blue Cross/Blue Shield of Texas which operated the Medicare program as an agent of the United States on a non-profit basis pursuant to a written contract executed under the provisions of 42 U.S.C.A. §§ 1395h and 1395u. All of the claims were paid by checks made payable to Dr. Peterson and mailed to him.

The circumstances surrounding Dr. Peterson's receipt and handling of the checks are far from clear. He testified that he assumed the checks were made out and sent to him because he was the medical director of Zodiac. He called his brother to find out why he got checks for physical therapy that he had not billed. James Peterson told him that "the claims had been filed." The doctor didn't ask why the checks had been made to him, nor did he contact Group Medical. He simply told James Peterson that he would forward the funds. Instead of endorsing the checks, Dr. Peterson deposited them to his own account and sent his personal check with a notation "account payable" to James Peterson, who deposited it in the Zodiac account.

Dr. Peterson was not on the payroll of Zodiac. He knew that the 120 checks payable to him did not belong to him. He knew he had never personally rendered any of the services in question. Subsequently and inexplicably, Dr. Peterson received six invoices from Zodiac for the therapy services rendered during the first six months of 1968 at Concord which comprised the 120 claims. Dr. Peterson did not pay the amount of the invoices because he "didn't think he owed the money." James Peterson's version was that Dr. Peterson had been billed for physical therapy services rendered while the doctor was medical director of Zodiac. He claimed that Dr. Peterson's check was in payment of the invoices. This is inexplicable because Dr. Peterson sent his check to James Peterson on June 3, 1969, and the Zodiac invoices were not prepared or sent to Dr. Peterson until July, 1969. Moreover, neither James Peterson nor Dr. Peterson could give any plausible explanation why Zodiac should bill its medical director for services its physical therapy department performed. Finally, also without explanation was the notation on Dr. Peterson's check to Zodiac, "account payable."

In July, 1969, a complaint was received by Gruninger, Program Integrity Specialist, Bureau of Health Insurance, Department of Health, Education and Welfare. The niece of a Medicare beneficiary at Concord questioned the payment to Dr. Peterson for physical therapy services not rendered by him. There followed an investigation concerning claims filed over the signature of Dr. Peterson for physical therapy rendered at Concord for the first six months of 1968 and sub-

mitted for payment in April of 1969. The investigation revealed that although Dr. Peterson's name appeared on the claim forms, he had not personally rendered the services, nor had they been performed under his personal direction. In December, 1969, because of the possibility of fraud, Gruninger issued a letter to Blue Cross/Blue Shield ordering suspension of further payments to Dr. Peterson under the Medicare program. In May, 1970, a conference was held with Dr. Peterson in which he was given an opportunity to respond to accusations made against him. Through counsel he subsequently replied by letter. The suspension, however, remained in effect.

Dr. Peterson responded by filing suit seeking to enjoin the defendants from wrongfully withholding funds due him under the Medicare Act. He also alleged that certain torts precipitated his suspension from the Medicare program. The Government filed a counterclaim against Dr. Peterson and a third party complaint against James Peterson for submission of false claims. A criminal indictment was also returned against the Peterson brothers which resulted in the conviction of both on one count of conspiracy, and of James Peterson on 39 substantive counts of submission of false claims (representing 39 of the 120 claims in the instant suit). On appeal this Court affirmed the conviction of James Peterson on the substantive counts and reversed the conviction of both Petersons on the conspiracy count.[4]

[4] See note 3 *supra*. The Court found that the jury lacked sufficient evidence to find Dr. Peterson guilty of conspiracy; reversing his conviction removed James Peterson's confederate, so the latter's conviction for conspiracy was also reversed.

Upon the trial of Dr. Peterson's complaint and the Government's counterclaim and third party claim, the district court found that Dr. Peterson was entitled to neither injunctive relief, nor tort or breach of contract damages against any of the defendants, and dismissed his complaint. The major portion of the trial was then devoted to the Government's claims. The court found that the Peterson brothers had violated the False Claims Act, 31 U.S.C.A. § 231, by knowingly submitting to the Government 120 false claims totaling $16,153.44, and thereupon entered a joint and several judgment for $31,606.72 representing double damages, together with the sum of $100,000 representing a $2,000 forfeiture for 50 of the 120 claims in question, with interest awarded from the date of judgment.

Dr. Peterson's Tort Claims

We first turn to Dr. Peterson's prayer for compensatory and punitive damages for the alleged tortious conduct of the defendants. He asserts that the Government and the individual defendants conspired to destroy him and to make it impossible for him to practice as a physician, and that the defendants took his property without due process, and wrongfully and maliciously interfered with his contractual rights. To support these charges, Dr. Peterson argues that he was wrongfully suspended from the Medicare program without notice or a hearing by employees of the Bureau of Health Insurance, H.E.W., who had no authority to impose sanctions, and that this was accomplished as a part of a conspiracy with the Government. Further, he complains that he was required to respond to criminal indictments and defend himself in a

criminal trial as well as defend against the Government's counterclaim for liability under the False Claims Act in the instant suit.[5]

[1] We have combed the record to find some basis for the numerous claims of tortious conduct on the part of the defendants and can find no evidence to support any of them. Evidence of a conspiracy between the Government and the individual and corporate defendants is non-existent. The suspension of Dr. Peterson and the withholding of payments due him by H.E.W. employees were actions both appropriate and necessary under instructions requiring the immediate suspension of any doctor participating in the Medicare program upon the discovery of possible fraud in the submission of claims under the Act. Bureau of Health Insurance Identical Memorandum No. 176, June 11, 1969. There is not a scintilla of evidence that the actions taken by the Bureau of Health Insurance employees were prompted by any reason other than to protect the integrity of the program. The corporate defendants, as fiscal intermediaries, did no more than act on the instructions received by them. This they were required to do. Convinced, as we are, that Dr. Peterson caused false claims to be made, we agree with the district court that the conduct of the defendants was neither malicious, negligent, nor unreasonable in the circumstances.

[2] Finally, we are unpersuaded that Dr. Peterson's property was taken without due process. His argument, premised

[5] Dr. Peterson has conceded that the Government is not liable under the Federal Tort Claims Act for malicious prosecution and interference with contract rights. See 28 U.S.C.A. § 2680(h).

upon Goldberg v. Kelly, 1970, 397 U.S. 254, 90 S.Ct. 1011, 25 L. Ed. 2d 287, is that H.E.W. was not entitled without a hearing to withhold funds due him under Medicare as an offset against false claims then under investigation.

We note that the district court, by preliminary injunction, ordered the withheld funds paid to Dr. Peterson upon his posting of a bond to indemnify the Government should the claims indeed prove false. This was accomplished. Since the funds were no longer held by the Government, this removes this case from the parameters of *Goldberg*. In any event, Dr. Peterson's argument is laid to rest by our decision in Hilburn v. Butz, 5 Cir. 1972, 463 F. 2d 1207. There, the Hilburn family were concededly owed money under various Department of Agriculture programs. After an investigation, the Secretary administratively determined that the Hilburns had been overpaid under the same programs in previous years and that the monies presently owed them should be applied to offset such overpayments. We held that the Secretary had the right to withhold current funds equal to the overpaid funds, at least until the issues relating to the overpayments were judicially determined. Judge Clark, reasoning in a manner eminently appropriate to this case, held *Goldberg* inapplicable saying:

> The result in Goldberg v. Kelly was based on a judicial notice of the fact that welfare recipients as a class would be deprived of their very means of existence while awaiting the outcome of a post-termination hearing. In turn, those recipients' necessary search for daily subsistence would adversely affect their ability to seek redress from the welfare bureaucracy. No evidence of any such dire consequences was adduced in this case. Hilburn v. Butz, 463 F. 2d at 1209.

We conclude that there was no denial of due process, and that Dr. Peterson wholly failed to prove tortious conduct on the part of any of the defendants; the district court properly entered judgment in their favor.

Immunity from Liability

The defendants urged the district court to dismiss Dr. Peterson's amended complaint for tort liability on the ground of official immunity. The court declined to do so at that stage of the proceedings, but, after hearing all of the evidence, concluded that their claim of immunity was well taken. We agree.

[3, 4] With respect to defendants, Secretary of H.E.W. and the United States of America, there can be no question that this was an unconsented suit against the sovereign over which the court lacked jurisdiction. The individual defendants were all employees of the Bureau of Health Insurance, Department of Health, Education and Welfare. McSteen was the Regional Representative responsible for the administration of the Medicare program in five states, including Texas. Adams supervised all of the work on fraud and abuse cases, including Dr. Peterson's case. Gruninger was a program integrity specialist whose responsibility it was to investigate claims of fraud and abuse and forward them for prosecution where indicated. Chancellor was also on the program integrity staff of the Dallas, Texas, regional office. He had the responsibility of contacting the families of beneficiaries who had been billed for services by Dr. Peterson. Dr. Peterson's case was processed and investigated in precisely the same manner as

other suspected fraud cases. His suspension was effected as required by Bureau of Health Insurance Identical Memorandum No. 176, June 11, 1969.[6] Peterson's argument that the individual defendants were guilty of gross negligence in improperly imposing sanctions on the wrong person, without just cause, in conspiracy with one another and with the Government, and outside the scope of their employment, is wholly unfounded. There is not the slightest indication that any of the individual defendants acted outside of their line of duty or the scope of their employment in carrying out their official responsibilities.

We find equally without merit Dr. Peterson's contention that the individual defendants were lower echelon employees who are not entitled to claim immunity. In the seminal case of Barr v. Matteo, the Supreme Court reasoned that:

> The complexities and magnitude of governmental activity have become so great that there must of necessity be a delegation and redelegation of authority as to many functions, and we cannot say that these functions become less important simply because they are exercised by officers of lower rank in the executive hierarchy. (footnote omitted.) . . . It is not the title of his office but the duties with which the particular officer sought to be made to respond in damages is entrusted—the relation of the act complained of to "matters committed by law to his control or supervision," Spaulding v. Vilas, *supra*, 161 U.S. [483,] at 498, [16 S.Ct. [631,] at page 637], 40 L. Ed. 780—

[6] The Memorandum provides in pertinent part: "Where cases of potential fraud are uncovered, the carrier should be instructed by the R.O. [Regional Office] to withhold payments in all pending assigned claims from the 'suspect' until the investigation is completed and conclusion reached as to whether fraud was perpetrated and, if so, what further action is to be taken."

> which must provide the guide in delineating the scope of the rule which clothes the official acts of the executive officer with immunity from civil defamation suits. (1959), 360 U.S. 564, 573—574, 79 S.Ct. 1335, 1340—1341, 3 L. Ed. 2d 1434.

Pared of distracting shadow contentions, the acts complained of were

> the result of a judgment or decision which it is necessary that the Government official be free to make without fear or threat of vexatious or fictitious suits and alleged personal liability.

Norton v. McShane, 5 Cir. 1964, 332 F. 2d 855, 859, citing with approval Ove Gustavsson Contracting Co. v. Floete, 2 Cir. 1962, 299 F. 2d 655, cert. denied, 374 U.S. 827, S.Ct. 1862, 10 L. Ed. 2d 1050. *See also* Scheuer v. Rhodes, 1974, 416 U.S. 232, 94 S.Ct. 1683, 40 L. Ed. 2d 90; Chafin v. Pratt, 5 Cir. 1966, 358 F. 2d 349. The alleged tortious acts were committed by agents of the Government responsible for the integrity of the Medicare program during the course of an investigation of purported violations of the Medicare Act; all the agents were shielded by immunity. Waymire v. Deneve, 5 Cir. 1964, 333 F. 2d 149.

[5] We need not tarry long with respect to the asserted tort liability and the immunity of the corporate defendants. They are Medicare fiscal intermediaries who act as agents at the sole direction of the Secretary of Health, Education and Welfare pursuant to 42 U.S.C.A. §§ 1395h and 1395u.[7] In

[7] Under regulations promulgated by the Department it is provided that "In the performance of their contractual undertakings, the carriers act on behalf of the Secretary, carrying on for him the administrative responsibilities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program. . . ." 20 C.F.R. § 405.670 (1973).

this situation the United States is the real party in interest. Under the doctrine of sovereign immunity, the district court lacked jurisdiction over all these defendants, both governmental and private as agents of the Government. *CF.* Pine View Gardens, Inc. v. Mutual of Omaha Ins. Co., 1973, 158 U.S.App.D.C. 294 485 F. 2d 1073; Johnson v. Johnson, E.D. Pa. 1971, 332 F. Supp. 510; Kuenstler v Occidental Life Insurance Company, C.D. Cal. 1968, 392 F. Supp. 532.

Government's Counterclaim and Third Party Complaint

[6] By its counterclaim and third party complaint, the Government sought recovery against the Peterson brothers under the False Claims Act, 31 U.S.C.A. § 231. As a common defense they urge that the Act was not violated because the physical therapy services were performed by qualified people, the patients receiving these services were entitled to them under Medicare, there was no financial loss to the Government, and the monies paid by the Government were therefore a liability which the Government was statutorily obligated to pay. This argument is unsound.

The claim forms here involved contain a place for the signature of physician or supplier, and the statement "(A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)." Each claim submitted bore Dr. Peterson's purported signature (written by Morton) certifying something that simply was not so: Dr. Peterson did not personally render the service, nor was it rendered under his personal supervision. The services were rendered by Zodiac who was not a certified provider. It

could not have been paid, had it submitted a bill to Blue Cross. Furthermore, it is abundantly clear that Dr. Peterson was not the medical director of Zodiac, nor had he any supervision over the physical therapist who actually rendered the services. In short, the services billed were plainly not "covered" services, and the Government thus paid on the basis of the false claims presented.

As a further common defense, the Petersons argue that there is no statutory or regulatory requirement for the physician's certification; thus, they contend, the certification is not material to the claim, so no liability can attach to a false certification. This contention is without merit. It is, of course, true that the statute does not prescribed the type of claim form required, but it does provide that under Part B the services must be performed by a physician or as an incident to a physician's service. It was entirely reasonable and necessary for the Government to require such a certification on the claim forms to implement the Act, and at the same time protect public funds. Obviously, a false certification on the claim form frustrated the Government's attempt to process only valid claims and led to the payment for services which were not covered or payable under the Act.

[7] James Peterson next argues that "there is no delineation as to whether the court found a 'false' statement or a 'fraudulent' statement. Further, there is no distinction as to the falsity or the fraudulence of the 'claim,' or whether there was a 'claim.'" This is a futile exercise in semantics. A claim is within the purview of the False Claims Act if it is

grounded in fraud which might result in financial loss to the Government. Simply stated:

> This remedial statute reaches beyond "claims" which might be legally enforced, to all fraudulent attempts to cause the Government to pay out sums of money. United States v. Neifert-White Co., 1968, 390 U.S. 228, 88 S.Ct. 959, 962, 19 L. Ed. 2d 1061.

The inclusiveness of the statute was spelled out in United States ex rel. Marcus v. Hess, 1943, 317 U.S. 537, 63 S.Ct. 379, 87 L. Ed. 443.

> These provisions, considered together, indicate a purpose to reach any person who knowingly assisted in causing the government to pay claims which were grounded in fraud, without regard to whether that person had direct contractual relations with the government 317 U.S. at 544-545, 63 S.Ct. at 384.

[8] Finally, James Peterson faults the Government for failing to bear its burden of proving *scienter;* he claims the evidence did not demonstrate his personal knowledge and participation in the false certification of the claims. In restating the applicable test, we said in United States v. Aerodex, Inc., 5 Cir. 1972, 469 F. 2d 1003.

> The law is settled in this Circuit that to show a violation of the False Claims Act the evidence must demonstrate "guilty knowledge of a purpose on the part of [the defendant] to cheat the Government," United States v. Priola, 272 F. 2d 589, 594 (5th Cir. 1959), or "knowledge or guilty intent," United States v. Ridglea State Bank, 357 F. 2d 495, 498 (5th Cir. 1966). *See also* Henry v. United States, 424 F. 2d 677 (5th Cir. 1970). 469 F. 2d at 1007.

James Peterson insists that he did not instruct Morton to

sign Dr. Peterson's name to the forms but simply told her "to get them out as soon as possible." It was Dr. Peterson's responsibility, so James Peterson contends, to prepare and sign the forms as Medical Director of Zodiac, but the preparation of the forms was done by Concord personnel as a convenience because the records were kept there. We are convinced, however, that the record fully supports the district court's finding that Morton signed Dr. Peterson's name and provider number and James Peterson's post office box number to the claims at the direction of James Peterson. We are equally convinced, for the reasons we have previously stated, that Dr. Peterson was not the medical director of Zodiac and that this was a title trumped up in an effort to circumvent the requirements of the Act. There was ample evidence to conclude that James Peterson had knowledge or guilty intent to make false claims against the Government.[8]

We have considered the additional attacks made by James Peterson on the findings of fact. They raise immaterial discrepancies that cannot be parlayed into a reversal. The findings are not clearly erroneous. McAllister v. United States, 1954, 348 U.S. 19, 75 S.Ct. 6, 99 L.Ed. 20. On the contrary, they have substantial support in the record. The

[8] On almost parallel evidence James Peterson was convicted on 39 counts under 18 U.S.C.A. § 1001 of the substantive offenses of unlawfully and knowingly making false statements of material facts to a government agency. This Court held that the overwhelming evidence established that Dr. Peterson did not in fact supervise the administering of physical therapy to any particular Zodiac patients, and that the evidence was sufficient to support the jury's finding that James Peterson had made willful misrepresentations on the claim forms filed with Group Medical and Surgical Service. United States v. Peterson, 5 Cir. 1974, 488 F.2d 645.

other errors asserted by James Peterson do not merit discussion.

Dr. Donald Peterson argues (in addition to the common defenses raised with his brother) that he is not personally liable under the False Claims Act because he had neither the intent to cause a financial loss to the Government nor the knowledge that the claims submitted by James Peterson contained a false or fraudulent statement. To support his argument, Dr. Peterson points out that he served as the medical director for Zodiac for the first six months of 1968. He knew the checks he received were for physical therapy services rendered by Zodiac at Concord and therefore thought this money belonged to Zodiac. He paid the money to Zodiac in good faith, knowing nothing about the contents of the claims filed. If this were the end of the story, Dr. Peterson would surely not be liable under the Act. But the parlous journey he began does not come to an end so quickly.

Not later than the first week in May of 1969, Dr. Peterson received from Group Medical and Surgical Service 120 individual checks made out to him totaling $15,803.36. Of these, 110 checks were dated April 28, 1969, and 10 checks were dated either May 1 or 2, 1969. Attached to each check was an "Explanation of Medicare" which set forth the name of the patient, that the services were provided by D. M. Peterson, D.O., his unique identifying number, the date and amount of the charge submitted, the amount allowed, the fact that the funds were assigned to the doctor, and the total amount of the Medicare payment. This "Explanation" and the accompany-

ing check, made payable to D. M. Peterson, D.O., were sent to Dr. Peterson at his correct address in Dallas, Texas. For some reason, left unexplained in the record, the checks were not deposited until June 9, 1969, over a month after their receipt. In the meantime, however, on June 3, 1969, six days before depositing the 120 checks, Dr. Peterson sent to James Peterson his personal check made to Zodiac.

[9] We reiterate that the district court was fully justified in finding that Dr. Peterson was not the medical director of Zodiac. He had no basis for assuming that the checks were sent to him because he was the medical director of Zodiac. On the contrary, the Medicare Explanation accompanying each check indicated that the claim was being paid to him personally and that the services were provided by him, under his unique identifying number, when in fact they were not. Under the circumstances, we agree with the district court that the act of Dr. Peterson in endorsing the checks and depositing them with the knowledge that he was not entitled to the proceeds was for the purpose of aiding James Peterson in obtaining payment and constitutes the making of a false claim as to each check. By this maneuver James Peterson and Zodiac ended up obtaining Government funds to which they were not entitled. The payment of the 120 claims would never have been questioned except for the complaints of patients who had never heard of Dr. Peterson.

Other Errors Asserted by Dr. Peterson

[10] Dr. Peterson complains that the district court erred in refusing to enter judgment for him for the sums, plus inter-

est, due him that were withheld during his suspension from the Medicare program. This issue is no longer viable. The district court granted a preliminary injunction in favor of Dr. Peterson, ordering that the Government pay him all sums due on claims which had been filed, and conditioned upon his posting a bond to secure the amount of any set-off that might ultimately be due the Government on its counterclaim. The bond was posted and Dr. Peterson received his money. Dr. Peterson is not entitled to interest for the period that the sums were withheld. "It is well established that the United States is not liable for interest in the absence of a contractual or statutory requirement to pay interest." United States v. Delaware Tribe of Indians, 170, 427 F.2d 1218, 1222, 192 Ct.Cl. 385. There is not statutory provision for the payment of interest under 42 U.S.C.A. § 1395, 28 U.S.C.A. § 1331, or 28 U.S.C.A. § 1361.

[11, 12] Next, Dr. Peterson argues that he was denied a fair trial because the court changed the order of proof, unduly limited his time for presenting his case, and acted as trial attorney for the Government. These charges border on the frivolous. The district court properly required that liability be established before proof of damages was offered, and it was within the court's discretion, which was soundly exercised, to initially try the issues raised by the counterclaim. Each witness offered on that phase of the case was, however, subjected to examination and cross-examination, without time limitation, in support of Dr. Peterson's claims of tortious conduct. Finally, the record is devoid of the slightest sugges-

tion that the court was an advocate for the Government. Moreover, these and other evidentiary errors asserted by Dr. Peterson were not the subject of objection below and cannot be raised for the first time on appeal. D. H. Overmyer Co. v. Loflin, 5 Cir. 1971, 440 F.2d 1213.

Dr. Peterson's contention that he was denied due process in connection with the suspension of his Medicare payments is unfounded. There is no administrative procedure prescribed by statute or regulation for suspension of Medicare recipients suspected of fraud. They, of course, have recourse to the courts for review of the action taken. Aquavella v. Richardson, 2 Cir. 1971, 437 F.2d 397. Here Dr. Peterson received a full hearing on the Government's claim of fraud.

Without further extending this opinion is is sufficient to say that we have carefully considered the various other issues raised by Dr. Peterson and find them meritless.

The Government's Asserted Errors

[13, 14] The Government urges that the district court erred in refusing to award interest on the fraudulent claims from the date the payment was made to the Petersons. We disagree. We subscribe to the view that since double damages, plus a specified sum, was provided in the False Claims Act for the purpose of making sure that the Government would be made completely whole, it is error to assess prejudgment interest on the recoverable amount. United States v. Foster Wheeler Corp., 2 Cir. 1791, 447 F.2d 100.

[15, 16] Finally, the Government argues that since the

district court found that 120 false claims had been filed, it should have assessed a $2,000 forfeiture for each false claim, or a total of $240,000, as provided in 31 U.S.C.A. § 231, instead of limiting the forfeiture to 50 claims totaling $100,000. The short answer is that the Government did not file a cross-appeal and may not now be heard to complain of the judgment entered below. In any event, the Government tacitly admits that the court may exercise discretion where the imposition of forfeitures might prove excessive and out of proportion to the damages sustained by the Government. The forfeiture should reflect a fair ratio to damages to insure that the Government completely recoups its losses. United States v. Hess, *supra;* Toepleman v. United States, 4 Cir. 1959, 263 F.2d 697. The district court used sound discretion in the imposition of forfeiture in this case.

We are satisfied that the issues were fully and fairly tried. The findings of fact have substantial support in the record are are not clearly erroneous. Proper legal conclusions were reached by the district court. Finding no error the judgment is

Affirmed.

EXHIBIT C

UNITED STATES of America,
Plaintiff-Appellee,

v.

James Eugene PETERSON and Donald M. Peterson, Defendants-Appellants.

No. 73-1748.

United States Courts of Appeals,
Fifth Circuit.

Jan. 18, 1974.

Rehearing Denied Feb. 19 and March 29, 1974.

Prosecution of two defendants, a physician and a nonphysician, for unlawfully and knowingly making false statements of material facts to a government agency, and for conspiracy, in connection with claims for payment for physical therapy services rendered. In the United States District Court for the Northern District of Texas at Dallas, Sarah Tilghman Hughes, J., the nonphysician was convicted of substantive offenses and of conspiracy, and the physician was convicted only of conspiracy. They appealed. The Court of Appeals, Gewin, Circuit Judge, held that, in view of overwhelming evidence that the doctor did not in fact supervise the rendition of physical therapy services, evidence which might have raised a doubt as to whether the physician was required to be personally present when the services were rendered, to meet a requirement of personal supervision, was properly excluded. The Court also held, however, that evidence was

insufficient to sustain the conspiracy conviction of the physician, whose signature on the claim forms had been forged.

Affirmed in part; reversed and remanded with instructions to dismiss conspiracy count of indictment.

GEWIN, Circuit Judge:

This appeal is taken from a judgment of conviction entered against Dr. Donald Peterson for conspiring to defraud an agency of the United States Government, in violation of 18 U.S.C. § 371 (1970).[1] His brother and alleged co-conspirator, James E. Peterson, also before us on appeal, was convicted under the conspiracy charge and on a number of counts under 18 U.S.C. § 1001 (1970)[2] alleging the substantive offenses of unlawfully and knowingly making false statements of material facts to a government agency. They were tried jointly before a jury which found them guilty. The prevarication is designated as the allegedly false certification that physical therapy rendered to patients at an extended care facility was provided by Dr. Peterson or under his personal auspices. Both appellants claim that numerous evidentiary errors were committed below and challenge the sufficiency of the evidence to support the jury's verdict. Finding these contentions to be of only limited efficacy, we reverse the conspiracy convictions but affirm James E. Peterson's conviction of the substantive offenses.

I

Before addressing the issues raised on appeal, it is instructive to consider the complicated statutory and factual back-

ground which gave rise to the instant prosecutions. James E. Peterson is the owner of Concord Manor, a nursing home approved by the Social Security Administration as an extended care facility and hence qualified to receive payment for hospital benefits rendered to the aged under Title XVIII, Health Insurance for the Aged of the Social Security Act, popularly denominated the Medicare Act.[3] The Act prescribes a bifurcated scheme of remuneration to those extending aid to the elderly. Under Part A, an extended care facility making outlays for room and board and nursing services may be compensated on a per diem rate determined by agreement with its fiscal intermediary, here Mutual of Omaha.[4] Under Part B, doctors rendering physical therapy are remunerated directly by a second fiscal intermediary, here the Group Medical and Surgical Service (Blue Cross-Blue Shield). Prior to July 1, 1968, Part B. claims were required to be filed by a physician on government Form SSA-1490(2), and could not be filed by a nursing home or medical organization comprised of physical therapists.[5] The 1968 amendment, however, altered this filing and compensation procedure by enabling a group of therapists, who form an organization to provide physical therapy and enter into agreements with extended care facilities to render the therapy prescribed by a patient's doctor, to bill directly for their services. It was this amendment which spurred the organization of Zodiac, Inc. by James Peterson and the fraternal interplay between James and Dr. Peterson. At his brother's behest Dr. Peterson enlisted as medical advisor to Zodiac, responsible for drafting procedures which would enable it to qualify as a "provider of services." Upon such

qualification, Zodiac would be entitled, under the new amendment, to bill directly for costs incurred in administering physical therapy to Medicare patients.

We turn now to the occurrences which gave rise to the institution of criminal proceedings against the two defendants. During the first six months of 1968, Zodiac furnished physical therapy to patients at Concord Manor. This therapy was administered by a registered physical therapist and two therapy aides. Dr. Peterson's involvement was purportedly confined to drafting procedures for submission to the Social Security agency, pursuant to the new amendment. Nevertheless, in 1969, Group Medical and Surgical Service received requests under his name for payment of medical insurance benefits for Zodiac patients receiving physical therapy from January to June 1968. These requests were submitted on Form SSA-1490D(2), alluded to above, which in box # 14, required that the administering doctor, here Dr. Peterson, certify that he either supplied the services or had them provided under his personal direction.[6] The forms received contained Dr. Peterson's signature, subsequently learned to have been forged, his personal supplier number, and a post office box address substituted for Dr. Peterson's registered address. The change of address was intended to divert the checks from Dr. Peterson's address to that of Zodiac. This was an abortive effort because Dr. Peterson's supplier number and address were unique to him and payment would be sent to Dr. Peterson automatically notwithstanding the change of address. Ignorant of the forgery and disregarding, as required, the substituted address, Group Medical and Surgical Service remitted claims

payments to Dr. Peterson, who after depositing them in his Dallas Clinic Account, upon the same day he received them, drew a new check for the same amount payable to the order of Zodiac. Both convictions stem from the conduct engaged in with respect to the filing of the claims.

II

The fraternal bond, welded by the joint employment of Dr. James Peterson in the Zodiac endeavors, appears to have been dissipated by the advancement of divergent theories for upsetting their convictions. The only semblance of unity retained throughout this appeal is that both claim that the prosecutors and the jury made "much ado about nothing." The premise underlying James Peterson's claim is that his brother was sufficiently involved in the operations of Zodiac affairs to dispel any inference that he, James Peterson, perpetrated a fraud in filing the claims. Conversely, the premise underlying Dr. Peterson's claim is that the evidence of his involvement in Zodiac affairs and the filing of claims is so meagre that he could not be found to have participated in the conspiracy. We consider their precise contentions advanced seriatim.

[1-4] James Peterson raises four contentions on appeal, each of which is devoid of merit. The first is that the lower court erred in excluding certain documents relating to Zodiac's qualification as a provider of services and two prior indictments which were dismissed. Second, the government's suppression of a letter from HEW addressed to Zodiac warranted reversal under Brady v. Maryland, 373 U.S. 83, 83 S.Ct.

1194, 10 L. Ed. 2d 215 (1963). And third, the lower court erred in failing to give requested charges and instructions which would have clarified the meaning of the phrase "under his personal direction." Each of these contentions fails, the first because under F.R.Cr.Proc. 26, it was within the district court's discretion to exclude the proffered evidence and such discretion was not abused in the instant case, *see* United States v. Twilligear, 460 F. 2d 79, 81 (10th Cir. 1972); United States v. Skillman, 442 F. 2d 542, 551 (8th Cir.) cert. denied, 404 U.S. 833, 92 S.Ct. 82, 30 L. Ed. 2d 63 (1971), the second, because James Peterson's characterization of the government's action with respect to the HEW letter as suppression is illusory, and the third, because the trial judge's instructions encompassed the substance of what James Peterson desired to have the court propound to the jury. A more formidable impediment to the efficacy of these evidentiary arguments is that the excluded evidence would be germane only if the theory upon which his defense is predicated were viable. This theory is that the meaning of the terminology "under his personal direction" contained in box 14 of Form SSA-140D(2) was ambiguous and hence any misrepresentation in filing the claims for payment was attributable to inadvertence and not to willfulness. The excluded evidence arguably gave credence to the view that some ambiguity prevailed.[7] However, whatever force his theory has derives largely from its generality, for the overwhelming evidence established that Dr. Peterson did not in fact supervise the administering of physical therapy to any particluar Zodiac patients. The inefficacy of his theory invariably condemns James Peterson's fourth

challenge, raised below through a motion for judgment of acquittal, and pressed here that the evidence was insufficient to support the jury's finding that he had made willful misrepresentations on the claim forms filed with Group Medical and Surgical Service. Evidence of Dr. Peterson's non-involvement in administering physical therapy clearly supports the jury's finding in this regard. Thus, James Peterson's conviction on the substantive counts must stand.

Dr. Peterson objects on appeal to two evidentiary rulings[8] and the sufficiency of the evidence to support the jury's finding that he participated in a conspiracy to defraud the government. He had raised this sufficiency objection in the district court by means of a motion for judgment of acquittal when the government rested its case, again when James Peterson rested his defense and reiterated it when all parties had closed their testimony by way of an objection to the submission of the case under the district court's charge. We confine our resolution to the sufficiency grounds.

Under established judicial precedent, a jury verdict must be sustained if there is substantial evidence when viewed in a light most propitious to the government, to support it. *See* Glasser v. United States, 315 U.S. 60, 80, 62 S.Ct. 457, 86 L. Ed. 680 (1942); United States v. Hernandez, 484 F. 2d 86, 87 (5th Cir. 1973); United States v. Arroyave, 477 F. 2d 157, 163 (5th Cir. 1973); Lacaze v. United States, 391 F. 2d 516, 519 (5th Cir. 1968). This rule, while dictating that deference be extended to jury findings, does not immunize them from attack. An examination of the evidence convinces

us that Dr. Peterson's challenge is well-founded.

[5] In reviewing the evidence marshalled by the government in support of the conspiracy charge, it is critical to note that conduct of Dr. Peterson subsequent to the time that claims were filed with Group Medical and Surgical Service is germane only to the extent that such conduct supports the inference that he had planned with James Peterson to file the claims containing the misrepresentation. Since the conspiracy had run its course *eo instante* upon the filing of these claims, Dr. Peterson's conduct upon receipt of checks in payment of claims could not constitute an overt act in its furtherance.[9] *See* Bollenbach v. United States, 326 U.S. 607, 611, 66 S. Ct. 402, 404, 90 L. Ed. 350, 353 (1946).

[6] The record is devoid of evidence, prior to Dr. Peterson's receipt of claims checks from Group Medical, which supports the conclusion that he had engaged in the alleged conspiracy.[10] Dr. Peterson steadfastly adhered to the position that he never directed the administering of physical therapy to Medicare patients and that he was ignorant of the forgery of his signature on Form SSA-140D(2). His testimony was corroborated by Helen Maeker, the registered physical therapist, and Lucille Morton, the secretary who at James Peterson's behest, forged Dr. Peterson's signature and attempted to substitute a post office box number for Dr. Peterson's registered address listed on the claims form.[11] Moreover, it is uncontroverted that Dr. Peterson expressly disavowed any intention to bill for services performed by Zodiac during his abbreviated affiliation and that he severed relations with Zodiac

after July 1, 1968, a substantial period of time before March 1, 1969, the date the alleged conspiracy transpired. Finally, there is no evidence that he saw, much less conversed with James Peterson after his disaffiliation, other than upon the day the claims checks were remitted to him. Hence, the jury verdict can only be sustained if Dr. Peterson's conduct upon receiving the checks supports the inference that he had pre-ordained the false filing engineered by James Peterson.

The evidence adduced by the government at trial established that upon receipt of payment checks from Group Medical totaling $18,000, Dr. Peterson reported their arrival to his brother, deposited them in his clinic account, personally wrote a new check designated accounts payable to Zodiac for the entire amount and delivered it to Zodiac on the very same day.[12] Dr. Peterson admitted that he took this action without making any attempt to contact Group Medical and Surgical Service about the checks and despite the fact that he knew the claims did not involve any of his own patients and that he had not authorized submission of the claims in his own name. The government also attributed significance to testimony elicited on cross-examination of Dr. Peterson which in allegedly impugning his credibility, reflected upon the mendacity of his assertions of noninvolvement in the claims filed.[13]

The countervailing evidence and that which compels the conclusion that the jury's inference of conspiracy must be set aside revolves around the actions of the alleged confederate, James Peterson. His conduct, in forging his brother's

signature, in supplying his supplier number, and in altering his registered address on the claims filed with Group Medical reflects a protracted effort to divert the checks from Dr. Peterson. Such an effort would appear to be inexplicable if Dr. Peterson were involved in the scheme. In short, Dr. Peterson's conduct appears to be more pickwickian than conspiratorial.

Moreover, we cannot overlook the fact that Dr. Peterson was exonerated of the charges contained in the 39 substantive counts of the indictment. Concededly, a conspiracy to commit a crime is a separate and distinct crime from the substantive offense. *See* Callanan v. United States, 364 U.S. 587, 593, 81 S.Ct. 321, 325, 5 L. Ed. 2d 312, 317 rehearing denied, 365 U.S. 825, 81 S.Ct. 687, 5 L. Ed. 2d 703 (1961); United States v. Jasso, 442 F. 2d 1054, 1056 (5th Cir.), cert. denied, 404 U.S. 845, 92 S.Ct. 146, 30 L. Ed. 2d 81 (1971); Downing v. United States, 348 F. 2d 594, 600 (5th Cir.), cert. denied, 382 U.S. 901, 86 S.Ct. 235, 15 L. Ed. 2d 155 (1965). But this distinction may become tenuous where, after receiving an "aiding or abetting" charge, a jury exonerates a defendant on the substantive count the elements of which closely approximate, if not parallel, the overt acts alleged in the conspiracy charge. We do not mean to suggest that were additional evidence of conspiracy adduced at trial a jury verdict of guilty on the conspiracy count alone would invariably require reversal. Rather, based on the unique facts presented in the record, it is difficult to conceive of how the jury could exculpate Dr. Peterson as an aider or abettor but yet inculpate him as a confederate.

III

[7, 8] For the aforementioned reasons, we hold that the jury lacked sufficient evidence to find Dr. Peterson guilty of conspiracy to defraud an agency of the United States Government. Concomitantly, since this absolution removes James Peterson's confederate, his conviction on the conspiracy charge must also be reversed. Since neither appellant joined a motion for a new trial with their motions for judgment of acquittal, the appropriate disposition is to reverse and remand with directions that the indictments be dismissed as to the conspiracy counts.[14] *See* United States v. Apollo, 476 F. 2d 156, 158 n. 1 (5th Cir. 1973); United States v. Musquiz, 445 F. 2d 963, 966 (5th Cir. 1971); 2 Wright, Federal Practice & Procedure § 470 (Supp. 1973). Since we discern no infirmity in James Peterson's conviction on the substantive counts, we affirm as to that part of the judgment of conviction.

Affirmed in part; reversed and remanded with instructions to dismiss the conspiracy count of the indictment.

---

[14] **Even if the record disclosed a motion for a new trial our conclusion would not be altered. The record convinces us that the Government has been given a full and fair opportunity to present all the evidence available on the conspiracy charge. The facts have been fully developed and no useful purpose would be served by another conspiracy trial.**

EXHIBIT D

UNITED STATES CONSTITUTION AMENDMENTS FIVE and EIGHT

Amendment 5

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; or shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Amendment 8

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

FEDERAL STATUTES

28 § 286. Conspiracy to defraud the Government with respect to claims

Whoever enters into any agreement, combination, or conspiracy to defraud the United States, or any department or agency thereof, by obtaining or aiding to obtain the payment or allowance of any false, fictitious or fraudulent claim, shall be fined not more than $10,000 or imprisoned not more than ten years, or both.

June 25, 1948, c. 645, 62 Stat. 698.

28 § 287. False, fictitious or fraudulent claims

Whoever makes or presents to any person or officers in the civil, military, or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be fined not more than $10,000 or imprisoned not more than five years, or both.

June 25, 1948, c. 645, 62 Stat. 698.

28 § 371. Conspiracy to commit offense or to defraud United States

If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined not more than $10,000 or imprisoned not more than five years, or both.

If, however, the offense, the commission of which is the object of the conspiracy, is a misdemeanor only, the punishment for such conspiracy shall not exceed the maximum punishment provided for such misdemeanor.

June 25, 1948, c. 645, 62 Stat. 701.

28 § 1001. Statements or entries generally

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any

false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both.

June 25, 1948, c. 645, 62 Stat. 749.

False Claims Act, 31 U.S.C. § 231[1]

[1]Relevant portions of this Act are:

"Any person . . . who shall make or cause to be made or present or cause to be presented, for payment or approval . . . any claim upon or against the Government of the United States . . . knowing such claim to be false, fictitious or fraudulent, or who, for the purpose of obtaining or aiding to obtain the payment or approval of such claim, makes, uses, or causes to be made or used, any false bill, receipt, voucher, roll, account, claim, certificate, affidavit, or deposition, knowing the same to contain any fraudulent or fictitious statement or entry . . . shall forfeit $2,000.00, and addition, double the amount of damages which the United States may have sustained by reason of the doing, or committing such act . . ."

42 § 1395(a). Free choice by patient guaranteed

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter in such institution, agency, or person undertakes to provide him such services.

42 § 1395g. Payment to providers of services

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or under-payments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Aug. 14, 1935, c. 531, Title XVIII, § 1815, as added July 30, 1965, Pub.L. 89-97, Title I, § 102(a), 79 Stat. 297.

42 § 1395nn. Offenses and penalties

(a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this subchapter,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made under this subchapter and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof

shall be fined not more than $10,000 or imprisoned for not more than one years, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1395x of this title), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months or both.

Aug. 14, 1935, c. 531, Title XVIII, § 1877, as added Oct. 30, 1972, Pub.L. 92-603, Title II, § 242(b), 86 Stat. 1419.

42 § 1396h. Offenses and penalties

(a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this subchapter,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such

benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this subchapter and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this subchapter) shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both.

Aug. 14, 1935, c. 531, Title XIX, § 1909, as added and amended Oct .30, 1972, Pub.L. 92-603, Title II, §§ 242(c), 278(b)(9), 86 Stat. 1419, 1454.

SUMMARY OF FEDERAL PENAL STATUTES
APPLICABLE TO MEDICARE AND MEDICAID CLAIMS

U.S.C. Title	Section	Applied To Applnt	Charge	Maximum Fine and/or Imprisonment	
18	286	Yes	False, fictitious or fraudulent claims	$10,000	10 years, or both
18	287	Yes	Conspiracy to defraud the government with respect to claims	$10,000	5 years, or both
18	371	Yes	Conspiracy to commit offense or to defraud United States	$10,000	5 years, or both
18	1001	Yes	Statements or entries generally	$10,000	5 years, or both
31	231	Yes		$2,000 and double damages	
42	1395(nn)	No	Offences and penalties	$10,000	1 year, or both
42	1396(h)	No	Offences and penalties	$10,000	1 year, or both

EXHIBIT F

UNITED STATES COURT OF APPEALS
Fifth Circuit

Office of the Clerk
March 27, 1975

TO ALL COUNSEL OF RECORD
Re: 74-1067 PETERSON v. WEINBERGER

Dear Counsel:

This is to advise that an order has this day been entered denying the petition( ) for rehearing, and no member of the panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12) the petition( ) for rehearing en banc has also been denied.

See Rule 41, Federal Rules of Appellate Procedure for issuance and stay of the mandate.

Very truly yours,

Edward W. Wadsworth, Clerk
By Anne G. Parent, Deputy Clerk

cc: Mr. Glynn A. Pugh
Messrs. Joseph A. Jenkins
James W. DeMik
Mr. Jerry Jordan
U.S. Attorney's Office
Mr. Kenneth J. Mighell